MEDICAL REVIEW OF TEXAS

[IRO #5259]
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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0146-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. C, MD

November 4, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedics. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Medical Director

CLINICAL HISTORY

___ was approved for a lumbar laminectomy in March 2004. He stated that after a lumbar myelogram it had been determined that his injury required a multi-level laminectomy and that the insurance company reviewers had determined that it was unnecessary.

A review of the claimant's file dated 8/5/04 from Concentra Integrated Services per Dr. C indicated that the proposed treatment did not meet medical necessity guidelines. The initial report stated that the initial surgeon had refused the medical necessity of surgery and the claimant had sought care from a second physician who had recommended epidural steroid injections prior to having surgery. The claimant apparently had refused the epidural steroid injections and had requested surgery. It was felt that the patient's history did not appear consistent with neurogenic claudications and that the physical exam was somewhat benign. It was felt that the risk of operation in a morbidly obese patient was significant. It was the reviewer's opinion that it was appropriate to delay definitive surgery in favor of conservative care, which would include weight reduction and epidural injections.

On 9/8/04 a review of the claimant's appeal to have surgery was completed. In this review the specialty adviser determined that the proposed treatment did not meet medical necessity guidelines. This opinion was supported by Campbell's Operative Orthopaedics.

Medical records included in the file indicate that the patient was seen initially at Concentra Medical Services in Houston on 11/9/03 indicating that he was unstacking pallets when he felt a snap in his left side and developed a constant pain in his left hip area radiating down to the back of his left leg. He was noted to have had previous back surgery in 1987. Physical exam demonstrated normal reflexes, normal sensation, and normal motor function to the lower extremities with a negative straight leg raising test. He had decreased active range of motion and some pain in the lower back with flexion and side bending. X-rays were taken, but no report is available. The diagnosis was

lumbar radiculopathy and lumbar strain and he was given medications for treatment of his problem.

He was seen again at Concentra Medical Services on 11/20/03 for a follow up of his lower back and left hip injury. He was found to have hypertension. His back exam showed moderate pain and stiffness and muscle spasm in the mid back and the lower back with decreased range of motion. Straight leg raising was positive on the left side and negative on the right. Reflexes, pulses, and sensation were normal in both lower extremities. The diagnosis was lumbar strain and physical therapy was prescribed as well as continuation of his medications.

The patient was apparently seen twice on 11/20/03. The second report indicates that he was seen in physical therapy on that date. He was noted to have flexion of 90° without pain and extension of 30° without pain. He was noted to have some left anterior hip pain with weakness of his left hip flexors and some left biceps femoris weakness. The assessment was that he presented with a lumbar SI sprain with radicular symptoms into his left hip area. Physical therapy plan was initiated on that date.

On 11/21/03 he was seen again at Concentra with notes that he was improving, but still had some pain in his left hip and into his testicle. He was taking Vicodin and Flexeril. Lumbar exam showed no significant point tenderness. He had a normal gait and reflexes were symmetrical. Testicular exam showed no abnormalities. Reflexes were intact. Sensory exam was normal. Motor strength was 5/5. The diagnosis was lumbar radiculopathy and lumbar straining. He was referred to an orthopaedic surgeon.

He was also seen in physical therapy that date with notes that he was having left lower extremity radicular symptoms. Therapy was discontinued. He was referred to an orthopaedist.

On 11/24/03 the patient saw Dr. L. He was complaining of back pain radiating into the left testicle area. His history was the same as previously. He was noted to have had a history of previous lumbar disc rupture and surgery at L5-S1 in 1987 with no problems since 1987. He was noted to be overweight with a normal neurological exam and a weakly positive straight leg raising test. An MRI was recommended as well as Vioxx and a Medrol Dosepak.

On 12/5/03 a lumbar MRI scan was performed. Findings included a suggestion of a laminotomy that had been previously performed at L4-5 with a 1cm posterior disc herniation at that level superimposed on facet arthrosis with mild central canal stenosis and bilateral foraminal narrowing. No abnormalities were noted at L1-2, L2-3, L3-4, and L5-S1 there was moderate facet arthrosis.

On 1/6/04 the patient saw Dr. J who apparently had done his previous surgery. He noted he had had a new injury on ___ and had started having groin pain, hip pain, and testicular pain on the left side. He was being treated conservatively but noted persistent pain. His neurological exam shows no localizing signs. It was Dr. J' opinion that he had an L4-5 disc that was herniated to the left side. He felt that physical therapy would be appropriate.

Handwritten notes on 12/22/03, which may be from Dr. J, indicate that the patient had been injured on ___ and had groin and testicular and hip pain and lateral thigh pain. Neurological exam reveals negative straight leg raising and no motor weakness with intact reflexes and normal gait. The impression was L4-5 disc. He was referred to physical therapy on that date.

Subsequent notes on 2/2/04 indicated that the MRI was reviewed. He had not had any physical therapy. He was having pain in his back and hip pain with ambulation. Neurological exam was normal and it was felt he still needed further physical therapy.

On 5/1/04 it was noted that his weight was now 340 pounds and it was recommended that he needed to lose more weight and that the patient was frustrated regarding his continued pain. It was noted that his mobility was limited and that he was unable to do routine exercises because they caused back pain. Aquatic therapy was suggested.

On 6/18/04 the patient was seen by Dr. C. He was complaining of back and bilateral leg pain, which had occurred after an injury on ___. He had subjective weakness in his left leg, but no bowel or bladder complaints. He had had medications and physical therapy and a previous laminectomy at L4-5 at age 22. Exam showed that the patient was 6'4" and weighed 340 pounds. His gait was normal. He had a well-healed incision on his back and a mildly restricted lumbar range of motion. Neurological exam was normal and tension signs were mildly positive. Review of his lumbar spine films

showed narrowing at L4-5 and possibly at L5-S1 and L3-4. The assessment was seven months of back and leg pain and a poor quality MRI. The patient apparently felt his symptoms were disabling. He felt he was a candidate for epidural steroid injections. The patient apparently was not interested in injections. Dr. C discussed surgical treatment with the patient and the fact that surgery might not improve his back pain due to the degenerative L4-5 disc. He recommended a lumbar myelogram CT.

On 7/7/04 the patient had a lumbar myelogram showing spinal stenosis at L2-3 and L3-4 with compressed thecal sac and a small spinal canal with mild ventral extradural defects compatible with disc bulging. He had no significant stenosis at T12-L1, L4-5 and L5-S1. A post-myelogram CT scan showed a mild annular bulge at L1-2 with mild narrowing of the spinal canal, significant spinal and neural foraminal stenosis at L2-3 with a broad-based disc bulge and facet hypertrophy, significant spinal and neural foraminal stenosis at L3-4 due to a disc bulge and facet hypertrophy, a mild broad-based disc bulge and mild neural foraminal narrowing at L4-5 and mild neural foraminal narrowing by facet hypertrophy at L5-S1. Lumbar spine films on that date show mild spondylosis at L3-4 and L4-5 and slight narrowing of the L4-5 disc space.

On 8/5/04 Dr. C wrote a letter indicating that the patient had been seen for reevaluation of back pain and bilateral leg pain. He reviewed the findings of the lumbar myelogram/CT study. He indicated there was canal narrowing at L2-3 and L3-4 and mild narrowing at L1-2. Exam showed mild tenderness in the left lumbar lumbosacral region and mild restriction of motion. Tension signs were positive on the left. Neurologically he was grossly intact. The impression was persistent back and bilateral leg pain with neurological compression at L2-3, L3-4, and less so at L1-2. It was his opinion that the patient was a candidate for lumbar decompression at L1-2, L2-3 and L3-4.

On 8/30/04 Dr. C saw the patient again. He was still complaining of pain in his back and both legs with numbness and tingling. It was reported that the lumbar decompressive surgery had apparently been denied. He again requested authorization for the proposed surgery. He noted that he had lost a significant amount of weight. He was of the opinion that ___ had significant neurological compression responsible for his back and leg symptoms. He noted that the patient had had conservative treatment and has opted against having epidural steroid injections. He felt he was a good candidate for laminectomy

and decompression. He felt that he should have an epidural steroid if surgery was going to be postponed to give him some symptomatic relief. He remained neurologically intact. Tensions signs were grossly negative.

A note from Dr. J on 3/8/04 indicates that the patient was seen on 3/5/04 with indications that therapy had not helped him. He felt that the MRI was consistent with a recurrent disc at L4-5 and that he felt the patient was a candidate for redo lumbar laminectomy at L4-5 and there was no indication for epidural steroid injections, as they would only be a temporary treatment for his problem.

REQUESTED SERVICE(S)
Medical necessity of proposed multi-level laminectomy.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
In summary, it would appear that the patient sustained a work-related injury to his lower back with resultant complaints of back and bilateral leg pain. Initial MRI scan did not show any evidence of spinal stenosis at L1-2, L2-3, or L3-4, but did show evidence of a previous disc problem at L4-5. Subsequent myelogram and post-myelogram CT showed evidence of mild spinal stenosis at L1-2, significant spinal neural foraminal stenosis at L2-3, significant spinal neural foraminal stenosis at L3-4, mild neural foraminal stenosis at L4-5, and slight narrowing of the neural foramina at L5-S1.

The clinical records do not support the primary symptoms of severe spinal stenosis, which are neurogenic claudication evidenced by leg pain with walking or standing, which is relieved by sitting or spinal flexion. There is no evidence in the medical records concerning any type of objective examination of neuro function in the lower extremities such as an EMG or nerve conduction study.

Based upon these findings, the medical records would not support medical necessity of multi-level lumbar decompressive surgery. The Agency for Healthcare Policy and Research Clinical Practice Guidelines #14 indicates on page 86 that "surgical decisions for patients with spinal stenosis should not be based solely on imaging tests, but should also consider the degree of persistent neurogenic claudication symptoms, associated limitations, and detectable neurological

compromise." The medical records reflect that there is no persistent evidence of neurological compromise such as motor weakness, reflex changes, or sensory changes. Likewise there is no objective evidence of any neurological compromised based upon EMG testing. The source of the patient's persistent pain, this reviewer believes, is uncertain in this case. One physician has recommended a repeat laminectomy at L4-5 and another decompressive laminectomy at three levels above this level.

The medical records reviewed would not substantiate the need for three-level lumbar laminectomy unless the patient had failed maximal conservative treatment. Complication rates for multi-level decompressive laminectomies in an obese patient are not insignificant and as the exact source of the patient's pain complaints are uncertain, the results of a surgical intervention would be unpredictable.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 5th day of November, 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: